

DELAWARE STATE MEDICAL JOURNAL

*Issued Monthly Under the Supervision of the Publication Committee
Owned and Published by the Medical Society of Delaware*

VOLUME 17
NUMBER 5

MAY, 1945

Per Copy, 20c
Per Year, \$2.00

PSYCHIATRY IN THE POST WAR ERA

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Mental disease from the viewpoint of the general population, has connotated, until recently, something mysterious which affected only the rare individual. This can readily be understood by the rugged and matter of fact personality of the early pioneer of this country who was occupied with battling the forces of nature and did not have the time needed for the rather philosophical and abstract thinking required for psychiatric understanding of the personality. Ancient history tells us that the early Egyptians, Hebrews and Greeks considered the insane as people who were either possessed of an Evil Spirit or were inspired as instruments of the Deity. With the rise of Greek and Roman civilizations various scientific, though incorrect explanations were adopted, resulting in the treatment of the patients by baths, drugs, exercise and other hygienic measures.

During about the second century of the Christian Era a great retrogression took place during which theories of witchcraft and demoniacal possession again held sway, continuing for 1600 years, no general change occurring in the United States until the 19th century. Even with the change of attitude of the more intelligent people, psychiatry as a specialty was the last to receive recognition by the medical profession as well as by the general population. This was probably the result of the fact that the bizarre behavior of some of the patients could not be explained by any obvious physical abnormality, and that those who presented less dramatic symptoms but still behaved in a manner which was contrary to the accepted norm of the time, were thought to be problems of controllable behavior and were not considered as ill. Until the early part of the past century the mental-

ly ill received no scientific care whatsoever. A few, during periods of religious excitement were burned as witches, others were kept by the family in locked rooms. Some were placed in jails because their behavior was a menace to society. Another group, since they had no visible means of support, were kept in alms-houses. Many wandered about the country and none received the most elementary medical care. A few foresighted physicians realized that the problem was one for the professional man and attempted to give aid, but these few had to forego scientific methods for more humanitarian causes in order that those mentally afflicted were properly housed and cared for.

The first institution built solely for the care of the insane was in Virginia in 1773. By 1844 there were only 23 hospitals, and in 1894 a total of 125, most of which were state institutions. According to the statistics of H. M. Pollock, in the year 1880, 40,942 mental cases were under treatment in public institutions in the United States. In 1920 there were 232,680, a six fold increase. According to the ratio per hundred thousand of population, there were 81 in 1880 as against 220 in 1920. There are some 750,000 people in institutions at the present time. With the increase in public knowledge the number is still increasing which will rapidly become greater for a time during the post-war era, because of the tremendous emotional trauma to millions of people subjected to the horrors of modern warfare and changes in living status for which they have not been equipped.

The physicians, who managed the early hospitals, did not have the basic knowledge for individual treatment nor could they bring to public notice, through research work and publication, the essential factors of mental disease. Also, because they worked in institutions on a salary basis, they were not considered to be as well equipped as their fellows in other branches of medicine. This idea was

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enhanced by the fact that during periods of shortage of physicians, superintendents were forced to hire incompetent personnel who were failures in general practice. As a matter of fact superintendents of hospitals were found to be of a high type of individual with a good knowledge of medical theory and practice and maintaining high ideals but who were hindered in their scientific work by the enormous load of detail work necessitated in managing an institution. It was their sincere desire to obtain a personnel with the same humanitarian ideals combined with a knowledge and desire for research work, but they were too often hampered by the fact that too few physicians wished to specialize in psychiatry nor did the medical schools offer the proper facilities for adequate training. At the same time too few medical students possessed the proper qualities for psychiatric therapy. The specialty, itself, demands a personality which is sensitive to the problems of others, which has the patience required to carry on a therapy which demands hours of understanding time for the individual patient, and who has adequate knowledge which enables him to cope with physical problems of all types which may occur in an institution. He must also have a complete knowledge of those diseases which effect the personality and be able to interpret correctly laboratory findings which may be influenced by emotional disturbance.

Unfortunately medical schools offered very brief courses in the subject, if any at all, in spite of the fact that a great portion of patients who appeal to the general practitioner for aid are neuro-psychiatric cases of the neurotic group. Many of these patients could be cared for by the general practitioner had they sufficient knowledge of the subject to carry on adequate therapy. As the situation stands these patients wander from doctor to doctor seeking aid. Often the psycho-neurotic symptom is fixed by inadequate treatment or improper therapy. Although institutions were built for the care of the insane early in the 18th century, lack of community interest and overwork required of the superintendents, made these asylums rather than hospitals. Fortunately since the last war the interest in psychiatry has increased markedly, since it

was found that a large number of young men were unfit for military duty because of emotional and psychotic difficulties. It is unfortunate that a tragic upheaval was necessary to arouse the public's interest to the necessity of drastic reforms in mental hospitals. Even today many civilians doubt the possibility of cure and assume a strained attitude towards those who have been forced to enter a hospital for mental disease. We must not overlook or underestimate the early work of Pinel, Dorothy Dix, Clifford Beers, Freud and others but the public's demand for drastic reforms was aroused when the fundamental principles and economic security of this nation was at stake.

At the present time veterans hospitals, as well as state institutions, have improved. Individual therapy is being undertaken, but the hospitals are still overcrowded, understaffed and the personnel is often hampered by large quantities of routine desk work which is of no help to the patient. The institutions for the care of the mentally ill, including veterans' facilities with their high per capita cost, are at a low level when compared with other hospitals, where the public demand for adequate care results in a higher level, and where the staff as well as residents and interns are carefully selected. At the present time the necessity for adequate psychiatric treatment is becoming more acute and the number of psychiatrists available has not radically increased.

Twice within a brief period of time devices for peace and sanity of the world have failed. Again the world is passing through a devastating war greater than any in all history. Up to the present time over one million men have been discharged from the armed forces for medical reasons alone. About 45% of these being neuro-psychiatric cases. These figures include the United States alone and the affect on other nations is still greater. This country was proud of its advance in psychiatry and psychology but it obviously failed since the percentage of the neuro-psychiatric casualties is much greater than those of the last war. There are too few clinics to care for those patients who are not in need of institutional care, since the additional casualties are not only limited to the armed forces but occurred among the civilians as well. Mobilization of

armies brought out the necessity of psychiatric study and treatment of the individual, since the unstable individual proved to be detrimental to the morale of the other members of the group.

When peace again occurs marked by destruction of whole countries, psychiatry will come to realize that it is one of the leading specialties, and that this specialty is essential for the rehabilitation of millions of people both military and civilian whose lives have been seriously dislocated by the war. It is psychiatry which can work either for the good or evil of the world, and it must be recognized that if the rules of human relationship are not carried out throughout the entire world, there may be another war which will result in the destruction of civilization. The increase in psychiatric casualties in the post-war period will occur when problems arise which are more difficult than those occurring on the battle front. The seriousness of these problems have not been recognized by the public and psychiatry must carry on an intensive educational program to prevent another disaster. People must realize that the old way of life will never return and that they must assume a broader aspect toward all nations, attempting to understand and interpret properly, national differences of thought.

During the period of actual warfare, the necessity for work and the need of helping those who are battle casualties, has helped to temporarily stabilize the civilian population, but this period will end and the disabled veteran will become an additional burden which, in combination with fundamental changes of the basic principles of life, will tend to cause the individual to seek an escape from his problems. Both the veteran and the civilian have faced factors which are new to the life situation. Never before has there been fighting on so many continents thus involving more civilian confusion and upheaval of the ordinary routine of life. Never before has there been as many young men and women forced to give up their schooling and business to fight for their country. Never since ancient times have the rules of decency in regard to warfare been so disregarded. Never has there been so much suspi-

cion and distrust among the allied nations themselves, a fact which makes the solution of peace terms more difficult and dangerous, instilling insecurity in every individual. Even the combatant himself becomes suspicious of the activities of his own country when he learns of the strikes and high rate of pay received by the civilian. Never have nervous breakdowns among troops and civilians been as common, possibly because of the intensity and ruthlessness of this war or of the breaking down of the higher type of civilization which has been developed, and which turns away from barbaric solutions of international problems.

The average American youth, raised in a country relatively young in the history of the world, was brought up to be tolerant of other nations. This tolerance and trust has caused the wealthiest nation in the world to suffer the initial reversal with which we are all familiar. It is no wonder that people, mentally unprepared to solve disastrous problems, become mentally ill because of the resulting conflict. Undue suspicion of other nations has been aroused combined with distrust which if not alleviated by mental hygiene, will cause post war international difficulties. This war has been so prolonged that emotional maladjustment will have greater opportunity to arise among the civilians. Had these civilians been prepared to face rapid changes in essentials of life, psychiatry would have fulfilled its place in medicine, and the second World War would not have resulted in an increase in maladjusted individuals unable to face the problems of life. Among the armed forces many will be demobilized with prejudiced minds while others will be frankly psychotic. The problem does not concern the allied nations alone but psychiatric treatment of enemy nations will be essential. Peace terms, determined by the civilians without consulting those who have suffered the most, may cause distrust and mental casualty among the enemy as well as the veteran.

At present one of the greatest psychiatric problems is that of a discharged soldier who must again obtain his trust in people and security in life. He must receive all opportunity to find his place in life. It is

true that a G. I. bill of rights has been passed but the law does not help the individual case to a satisfactory degree. Veterans have been sent from agency to agency, some being refused a chance of rehabilitation because of a lack of personnel. When this occurs he may, after a short time, find that disability is of more value than ability. Years of warfare have changed the personality of the soldier and the civilian and they may never be able to again revert to the former type of a life of tolerance. All of these discontented thoughts and fears are subconscious, as is also the thought that "nerves" are acceptable to the community and gives the veteran a life long pension. The purpose of psychiatry is to rehabilitate the individual so that he may become self supporting. The average individual, who comprises the bulk of the population, depends upon his job or profession and he is the true citizen who has made this country what it is. These people are fearful when their plan of life is broken by such a catastrophe as war. This fear, in combination with abnormal living situations, produces a fertile ground for a mental break.

An attempt was made to rehabilitate the veteran in the last World War by offering education in trades and professions. However, there were many errors which must now be avoided, the avoidance of which needs the help of a psychiatrist. Educational opportunities were offered by desire rather than ability. Many men had come from isolated districts or had had 8th grade education or less. Reading was irksome and studying practically impossible. Thus many of these potential students became community liabilities, often assuming an attitude of defeatism. Psychiatry must see that these errors are not repeated and that those requesting educational opportunities be studied thoroughly to determine their ability and emotional fitness to carry on the course requested, and to succeed when the course has been completed.

Treatment of the mentally disabled individual requires job finding, case work, family study and education. Financial support should only be given for a limited time in order that the individual does not feel a sense of failure in initiative and responsibility for his own welfare. Psychiatry, in its high-

est sense, tends to restore the individual to the greatest level possible, not necessarily obtaining a complete cure. The end result of treatment means restoration to work, recreation and utilization of all human value. The main function in psychiatry relies in reorientation of the individual's own emotional problems and freeing him from trifling anxieties and feelings of insecurity. This may be done either by individual or group therapy. In considering the factors presented above which were caused by the recent world upheaval, it is tragic that this branch of medicine did not receive the attention it deserved, and that the medical schools did not consider the importance of this specialty as one of the major subjects in the study of medicine. In fact the specialty is a part of internal medicine and the psychiatric aspects of disease should be taught as an integral part in medical courses.

Although marked strides have been made in institutions for mental diseases in the last 15 or 20 years, the country is not equipped with enough clinics to care for ambulatory cases. True the institutions have not reached the highest ideals and have deteriorated considerably during the war period due to lack of personnel and equipment. In spite of this fact, drastic therapies have been used with considerable success, however, with gross neglect of research work. Every hospital now greatly overcrowded must be reorganized and restaffed. Acute mental and nervous cases should be considered in the same category as other diseases and the expense of treatment carried by health insurance. Standards should be adopted and hospitals not arriving at these standards should not be accepted by any of the medical organizations for training purposes. With the more adequate instruction of medical students in psychiatry, the number who accept this specialty will be greater. Internship will be of a psychiatric nature. In fact the old family physician of 25 years ago instinctively carried on psychotherapy, but the modern era of specialization increased the load of the psychiatrist in the psychiatric hospital since neuro-psychiatric cases were rejected by other specialists. In order to interest the medical student in this problem, more re-

search work must be done that the scientific aspect of the mental case will be better understood.

Therapeutic approaches in internal medicine and surgery are clear cut, but for successful psychiatric therapy, in addition the physician must be one who is able to interpret the reactions of others without his own emotions clouding the picture. True the radical therapies have produced more cures in certain types of patients, but the psychiatrist is still working blindly as to why these cures occur. Preventive psychiatry should play a more important role than at present. Children should be examined in order to obtain a knowledge of their abilities and emotional characteristics in the same manner as they are examined to determine if they have diseased tonsils or teeth. They should be seen by a psychiatrist to determine personality trends and abilities and, if abnormalities are found, therapy should be instituted at an early age in order that maladjustment may be avoided.

Mental hygiene should become a part of the curriculum of all schools. This unfortunately has been disregarded and the emotional abnormalities have not been recognized by the teacher but have been considered as behavior difficulties. At the same time more patients, who are now in institutions, should be allowed to live at home and the family educated in the proper care and treatment, thus avoiding overcrowding of hospitals and giving the individual an environment which more nearly approaches the normal. With a greater knowledge of mental health, individuals will be able to solve their problems in a more satisfactory basis. With increased knowledge there will be a greater demand of standardization of hospitals and pressure will be borne on legislatures to provide the necessary funds to maintain these standards. The public will also recognize that mental deviations are merely diseases and they will be allowed to come to the hospitals voluntarily in the early states without legal procedure which in itself is detrimental to the individual.

The future of psychiatry is one of development and education. Years ago the public was aroused by the disabling factors of

physical diseases until, at the present time, group insurance is common but does not pay compensation for psychiatric disorders, many of which are of short duration and curable. Certain types of cases should be allowed to enjoy the benefits of such. Colleges and schools have given little attention to Mental Hygiene. Physical examination of school children has been compulsory at stated intervals, but mental examinations have been ignored. Parents, not knowing the laws of mental health, have ignored or excused the defects of their children or have punished them, thus increasing the problem and developing grounds for future mental disease. Local, county, state and federal governments have paid little attention to psychiatry, considering the problem as one of maintenance. The American Medical Association, the representative organization of American medicine, has treated psychiatry as a step child. Now the families of disabled veterans will demand more adequate care which will result in a revolution of psychiatric medicine. Psychiatry will be forced to assume its proper position among the other specialties.

Since there are only about 3,500 psychiatrists and since it is estimated that about 20,000 will be needed to carry on the work in an acceptable manner, the intelligent layman must be educated to help carry on the work until psychiatry is able to prepare the men needed. Although hospital and out-patient facilities can be improved within a few years, it requires nine years of studying from the time a student starts his medical education until he can be considered a well versed psychiatrist. It is therefore reasonable to estimate that a period of ten years will elapse before there will be sufficient personnel to give the optimum required service. The reorganization and advancement of psychiatry will take into consideration preventive measures, hospital aid and out-patient care.

In considering the program of preventive measures it should be emphasized that the subject of mental hygiene should be taught in all schools even as that of public health is taught today. This education can be started in a simplified form in the first grade. Experiments in the teaching of human relations

were carried on in the Delaware schools and were quite successful considering the short time which elapsed before the war reduced the personnel to such a degree that only emergency work could be carried on. This class was carried on under the direction of Colonel Bullis and a preliminary text book was published. The primary object of these classes was preventive in nature although some therapeutic results were obtained among children who are adjusting poorly. In high schools and in colleges, the subject of mental health should become a required course so that those educated in the higher schools and who naturally become leaders in their community, will not only learn to solve their own emotional conflicts and control their emotional life so that they will be in no danger of maladjustment, but will also be able to understand and give aid to others in their community who have not had the privilege of obtaining the required knowledge to live a healthful and helpful life. These people should also learn something about the fundamental aspects of organic psychiatry so they will be able to recognize the onset of symptoms and see that any individual suffering from such, receive the proper care.

Hospitals for the care of the mentally ill, should be relieved of the burden of overcrowding by the erection of new buildings and by a weeding-out process of senile cases, whose mental disease is of such a nature that they can adjust in special institutions. They should have adequate personnel, particularly among the medical and nursing staffs, so that acute cases may receive intensive therapy. Again we wish to state that the health insurance plants should recognize these patients as being truly ill and that the policy holder should receive benefits for a certain period of time which is adequate for cure. These hospitals should have all the facilities of any well recognized general hospital and should not be considered as first class hospitals unless these facilities are present.

Everything possible should be done to prevent legal commitment or court examination for admission of the individuals to the hospitals. As the public becomes more oriented in regard to mental disease, voluntary admission will be sought for and should be

allowed. As it is in some states, legal commitment would then be considered only for the patient who is deleterious to the welfare of others or to the individual who is criminally insane, and could be considered on the same basis as an individual suffering from a contagious disease, who must be quarantined for a period of time. Thus the commitment of the dangerous patient should be in effect only while the individual is a menace to society. In order that the optimum conditions be arrived at, hospitals should be free of all political control.

In addition to the psychiatric work, which is carried on by the psychiatrist, nursing staff and recreational staff, neurosurgery should be used to a great extent for those patients needing such service. The more radical therapies such as insulin, electroshock and deep narcosis are being carried on in most of the institutions, but much research work must be done in order to obtain a greater understanding of the therapy. In addition, hospitals for the mentally ill should maintain a close contact with general hospitals and with internal medicine and endocrinology. The recognition of mental symptoms in the early stages of physical disease, will enable the psychiatrist to work with the other physicians in order to prevent prolonged emotional instability.

The third factor is one of out patient service. Clinics should be established which could be on a part or full time basis, which are available to all and located in larger communities, preferably in close connection with general hospitals. Unless private, the clinics should be affiliated with hospitals, universities or public health departments, so that exchange in service can be expedited. The clinic should be in charge of a well trained psychiatrist, who, if he has assistants, may have control over a group of clinics offering service to a large community, or even state.

The policy of the clinic should be to accept for service, persons referred by a qualified agency, who are in need of psychiatric aid. If a psychiatric disorder is discovered it should be prepared to offer out patient treatment or to secure such therapy as is indicated. Its duties should include diagnostic and therapeutic services, pre-hospital service, examination and treatment of non-hospital cases, both

adult and children, and supervision and treatment of convalescent post-hospitalization cases. The clinic should act as a consultant for various agencies and should include in its scope a well organized educational program. In this way psychiatric care will be available to all.

In closing let us state that it is tragic that a world upheaval must occur to awaken the population to the great problem of mental maladjustment and to make them realize that until adequate care is obtainable, chronic cases will increase in number, and their liability to the population will become ever greater. No longer can we say that only the inherently weak individual becomes a mental casualty since it has now been proven that the best trained and the strongest individual may reach a point in life, where he can no longer face his problem logically and he seeks escape by becoming one of the great mass of maladjusted individuals. These people can be rehabilitated and become useful members of society if proper hospital and out-patient care is available, and if they are trained to recognize that they need treatment. On the other hand, the difficulty may be avoided if the individuals have a proper knowledge of mental hygiene obtained in school or early in life.

AN ATYPICAL CASE OF CEREBELLAR TUMOR

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Brain tumors are relatively rare in general medical practice and the average physician relies on the three major symptoms in making a diagnosis; namely headaches, projectile vomiting and papilloedema. Many a physician never encounters a case during his practice and therefore is often non-familiar with the variation of symptoms which may occur. Therefore mistakes in diagnosis may occur which endangers the patients' life by delaying operation. An atypical case is presented. This case had had various diagnoses before typical symptoms arose which led to immediate operation.

The patient, a 38-year-old woman, was admitted because of headache, nausea, extreme nervousness, and some menstrual disturb-

ance. Before admission to the Delaware State Hospital she had been in a general hospital for study, but since no definite pathology could be found she was transferred to the Delaware State Hospital with the diagnosis of psychoneurosis. Family history was negative with the exception that one brother suffered from mental retardation. Patient was described as living a normal life, but the fact that she suffered from stomach ulcers at one time suggested the diagnosis of psychoneurosis when no persistent physical nor laboratory pathology could be found.

In November, 1943, she fell down stairs accidentally. At this time she states that she was stunned but probably not unconscious. There was no other history of disease nor injury to the brain. In December, 1943, she first began complaining of ill health, these complaints consisting of visual disturbance and headache. Thinking that her glasses needed changing she consulted an optometrist, undergoing a thorough examination. After returning home she started vomiting and continued to do so constantly. The possibility of pregnancy and gall bladder disease was considered, but no treatment administered by the local physician helped her. At this time she claimed that her eyes would not focus properly. She remained in bed at her home for three weeks and then was transferred to a general hospital under the care of an internist. Here her eyes were again examined and the fundi found to be normal. X-ray of the gastro-intestinal system showed no abnormality. The urine on two occasions showed the presence of sugar and acetone but the blood sugar was within normal limits. Blood chlorides varied from 594 mg. to 405 mg. Spinal fluid examination was within normal limits. Since she did not improve, she was transferred to the Delaware State Hospital February 28, 1944, with the diagnosis of psychoneurosis.

The patient was brought to the hospital by ambulance since she was too weak to walk. Physical examination showed a slender, dark woman who was in a poor state of nutrition. There was an area of pigmentation on the abdomen but none on the mucus membranes. On admission the blood pressure was normal but a few days later often could not be obtained.

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She usually had a slight elevation of temperature daily and the pulse rate was rapid and weak. There was a marked hypertrichosis of the face, legs, and abdomen. She vomited continuously but without force. Vomitus was copious and contained bile. She complained of dizziness which was relieved when she closed her eyes. When her head was elevated she had a sensation of impending death. The patient was too ill to talk to any great extent but did state that in November she had had a severe attack of influenza. A few days after admission vomiting became slightly projectile in nature.

Neurological examination on March 4th was negative except for a lateral nystagmus and a slight rigidity of the neck muscles. Laboratory examination showed blood chlorides to be 370 mg. on March 1st which rose to 420 mg. by March 4th with sodium chloride therapy. X-ray examination of the skull, lungs and abdomen were normal. Endocrinological study was made without arriving at a definite diagnosis but it was thought that she might be a case of adrenal hyperplasia which underwent an acute deficiency following "the gripe." She was placed on a regime of cortate and sodium chloride. With this treatment she improved for a few days but on April 3rd the symptoms reappeared and blood pressure could not be obtained. Emergency methods were used and codeine was used for headaches.

On April 7th her condition became much worse. Patient was hiccupping and the pulse pressure could not be obtained. The left eye ground showed a distinct papilledema and multiple hemorrhages. The right eye ground revealed a slight enlargement of the veins. There was a marked nystagmus when the eyes were turned to the right. Muscular response was weaker on the right side of the face. There was a brief unsustained foot clonus on the left. Plantar reflexes were feeble on the left side and doubtful on the right. At this time there seemed to be no doubt that the patient had a mass lesion of the brain and she was sent to Philadelphia for neuro-surgical study. Here it was again noted that the patient presented a rather puzzling picture with the most prominent symptoms being nausea and vomiting. Again, bilateral nystagmus was noted. There was either weak-

ness or incoordination of the right extremities and a definite right facial weakness. Due to the absence of definite localizing signs it was impossible to determine whether a cerebellar or cerebral lesion was present although it was felt that the woman was undoubtedly suffering from an intracranial lesion.

Under local anesthesia a ventriculogram was done which showed two large ventricles containing approximately 60 to 70 cc. with the dye passing readily. Air studies showed that the aqueduct was dilated thus indicating a suboccipital craniectomy. Under intratracheal anesthesia the usual suboccipital craniectomy was done, the foramen opened and the atlas removed. The dura was promptly opened from below upward and a tumor was exposed in the midline. This tumor seemed to be encapsulated with a fair line of cleavage. It was enucleated by finger dissection and it was all removed with the exception of a small portion which might be present directly under the tentorium. However, it was felt that the aqueduct was unblocked and the patient relieved of her more painful symptoms. Her condition remained good during the operation and recovery was uneventful.

Microscopic examination showed the tumor to be a medulloblastoma, somewhat atypical in formation. Some of the early symptoms, however, were quite characteristic of a cerebellar tumor, namely dizziness, headaches and vomiting, and the rigidity of the neck. There was some tendency to hold the head to one side in order to free circulation of intraventricular fluid.

Due to the fact that choked discs did not develop immediately led to some difficulty in diagnosis. The fall was probably an early symptom rather than a causative factor.

Although this patient is still alive and is relieved of some of her painful symptoms, neurological symptoms are becoming more evident.

The onset so resembled a psychoneurosis that the diagnosis could only be made when choking of the discs suddenly occurred.

This case shows that intracranial lesion may well be present without definite physical signs. Although such a lack of symptoms is rare, the physician must always be alert when caring for cases of psychoneurosis for the onset of some serious pathological lesion.

PSYCHIATRIC PROBLEMS OF SERVICE MEN'S WIVES

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In the cases referred for diagnosis and treatment to the Mental Hygiene Clinic there has been a steadily increasing number of wives of service men. A search of the records of the past year reveals twenty-three of these service wives each presenting some problem of personality, adjustment or conduct which brought her properly within the province of clinical psychiatry.

Much has been written by lay writers for lay readers on the subject of service wives. Some such writers have classified the women neatly into categories based upon their reactions to the situation of being deprived of a husband during a war. Examination of some of these articles reveals an extremely superficial view of the subject.

In this study it is found that disturbed adjustment is not necessarily due to the husband's absence, but, in some instances, to his presence. A psychiatric clinic cannot study a cross section of service wives, because those who adjust well are not seen. Even the sex delinquents came to the attention of the Clinic only as juvenile offenders or because of incidental neglect of children.

Two wives of essentially normal personality and adjustment consulted the psychiatrist because of natural worry and concern over husbands who obviously were not reacting normally to military life.

By far the greatest proportion of the group, as would be expected, fall into the classification of psychoneuroses. Fourteen of the wives are placed in that group. Some of these are of moderate severity and might properly be classified as simple maladjustment. However, each one presents definite symptoms of psychoneurotic nature and consequently is diagnosed as psychoneurosis.

Eight of the fourteen are reactive depressions. Two are anxiety states. One is a compulsive neurosis with vocal and facial tics. Three are mixed psychoneuroses showing manifestations of reactive depression associated with symptoms of one or more additional

types. In ten of the women classed as psychoneurotic the condition became manifest or was aggravated by the husband's absence. Four were worse because of the husband's temporary or permanent return from service. The writer was impressed by the occurrence in this small series of four cases of sexual frigidity. Two of the four wives made worse by the husband's presence were frigid. The other two frigid women had strong emotional attachments to the husband. One developed numerous psychoneurotic symptoms when the husband went away. The other, an intelligent, cultured woman of Jewish extraction, who came to the United States just before the war, suffered attacks of anxiety and unreasonable fears. She was the wife of a medical officer stationed in Delaware. She was willing to cooperate fully in efforts to correct her difficulties and was started on a series of modified psychoanalytic sessions which were interrupted when her husband was suddenly transferred to the Pacific Coast.

Three of the four frigid women were mothers. Two of them had illegitimate children before marriage. The one childless wife in the frigid group objected to any effort to change her attitude toward sex, though extreme marital maladjustment and discord had resulted. Another young woman was so disturbed by the thought of having to submit to sexual relations with her recently discharged husband that she developed a severe depression and seriously contemplated suicide.

Several wives in the psychoneurotic group were found to have added to their troubles by neglect of such elementary things as nutrition, rest and elimination. A young negro woman became depressed, neglected to eat and lost much weight. When seen she complained of weakness, shaky feelings in the abdomen, giddiness and heart consciousness. Rapid improvement ensued when she was placed on a high calory diet and began to regain the lost weight.

A woman employed in a war plant complained of tremulous sensations in various parts of the body, thumping in the head and giddy attacks. It was learned that she scarcely ever ate a balanced meal, but lived mostly on soft drinks, sweets and pastries.

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Still another woman working in a factory complained of giddiness to such a degree she feared she might fall into a machine. It turned out that she never ate breakfast, had little lunch and drank many cups of coffee in the course of the day. Incidentally, insomnia was one of her chief complaints.

Failure to engage in useful activities was scarcely encountered in the group. One of the psychoneurotics had never had a job. Three had given up jobs because they thought "a rest" might be good for them. Of the remainder, those not employed in industry were occupied with the care of children and with household duties. Thirteen of the twenty-three wives in the total series are mothers.

Six women were seen in whom sex delinquency and promiscuity were the chief problems. This small group contains the oldest woman of the series, aged forty-two years, and the youngest—three girls of seventeen. The other two were eighteen and twenty-two. Five of the six are mothers. One had two children before she was seventeen. All the five mothers were accused of neglecting their children. The sixth was found living in a man's apartment. The social histories of all six reveal that they have poor family backgrounds and have been subjected to unfavorable environmental influences. Four of the six were known as conduct problems before the husbands were inducted. Invariably these women accused their husbands of infidelity, abusiveness or neglect. Three of the younger ones might be classed as amoral in that they appeared to have no ethical standards upon which to base their conduct. In all these cases the fact of the husband being in service was of little importance in the development of the conduct pattern. Defective intelligence was not a factor in any of the cases.

Of the two wives of essentially normal personality mentioned earlier, one was unhappy because her husband had adjusted poorly in service. She feared, with good reason, that her marriage was seriously jeopardized by the husband's induction. The other, a nurse, wanted to discuss with the psychiatrist the mental state of her husband. The man's behavior during a furlough and his letters indicated that he was subject to attacks of de-

pression during which he expressed very unkind feelings toward the wife. During more normal periods he wrote normally affectionate letters. The wife was disturbed and perplexed by this inconsistency in her husband's attitude. She derived much understanding and comfort from the interpretation of the situation offered by the physician.

The final case is that of an Italian girl married to a man of English ancestry. The girl was always a misfit in her family. She married her husband after a brief acquaintance while he was on furlough. While the husband was in service the wife lived with her grandparents and adjusted reasonably well. Since the husband has been discharged the wife has developed more striking personality peculiarities suggestive of a schizophrenic development. She makes excessive and fantastic accusations against the husband which are not confirmed by any other source of information.

This group of cases seems destined to grow more rapidly in the future just as the case load of psychiatric problems in discharged veterans is growing. The need for special facilities to handle the increasing number of cases becomes more clearly evident each day. The outline of the necessary organization is beginning to appear. It seems likely that the supply of trained workers will be severely taxed for a time at least. It is inevitable that the need will eventually be met.

THE PSYCHIC EPILEPTIC VARIANT

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Among the many unsolved problems in the sphere of the epilepsies the topic of the psychic seizure, the psychic equivalent or variant is still short of a mystery. It seems that nearly every student plying this field has the opportunity of diagnosing it, yet there are as many concepts in existence as there are observers.

Because of the many shades and symptoms of the psychic attack it seems almost futile to allocate a definite position to the psychic variant in the system of epileptic conditions. It is, however, indispensable to scrutinize the

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various concepts at hand in order to gain a more lucid notion of the subject matter.

According to Tredgold¹, attacks of psychic epilepsy consist "of a disturbance of consciousness involving the highest discriminating level only, and the motor discharge takes the form of perfectly coordinated and apparently purposive actions."

"While attacks of this kind occur in persons who have never been known to have an ordinary seizure, they may also alternate with these latter. They are then known as epileptic equivalents."

W. F. Roth² groups under the general heading of psychic seizures three different reactions. He distinguishes transient "absences" or petit mal attacks, automatism (psychomotor attacks) and illusional ("dreamy state") seizures.

Hinsie and Shatzky³ arrive at a definition of the epileptic equivalent by mere exclusion from the grand mal and petit mal types. "The commonest epileptic equivalents appear as automatic motor acts, such as fugue states, followed by amnesia." In his discussion of psychic epilepsy, Brill⁴ has stated that "it resembles the pre- and post-epileptic manifestations, differing from them in the absence of the epileptic convulsions only, or the convulsions may be so brief as to escape notice."

It seems most unfortunate that even in modern texts the reader is confronted with a confusing terminology and confusing interpretations.

Penfield and Erickson⁵ who wish to have the term psychic epilepsy replaced by the expression "psychical precipitation," state that the terms psycholepsy and epileptic temper are used synonymously with epileptic equivalent (their critique of such lack of discrimination would be desirable, of course) and deem it "wiser to discard the expression epileptic equivalents as these conditions are either due to true seizures or something else altogether."

In this connection Kinnier Wilson's⁶ comments deserve attention. "The epileptic temper has often been described, but whether its substitution for fits makes it a true equivalent is uncertain, in view of its appearing also in

families with insanity as a feature though without epilepsy."

For much the same reasons, it seems, the term psycholepsy should not be used to denote a psychic epileptic equivalent.

Kinnier Wilson finds the term "equivalent" objectionable on the grounds that, the underlying processes being the same "as those inducing physical epileptic symptoms, then these psychical syndromes are not equivalent to epilepsy, but in fact, epileptic." He advocates the more neutral term "psychic variant."

Bing⁷ suggests that "the reason certain transient psychic phenomena are considered epileptic in nature is that they frequently occur in individuals who have (or have had) epilepsy, or they affect persons in whose families epilepsy is present. Three other reasons for assuming that psychic fits are epileptic in nature are (1) that the patient's consciousness is dimmed during an attack, (2) that a very definite depression follows such an attack, and (3) that some patients afflicted with this condition react remarkably well to bromide medication." In his discussion of the psychic fits he lists as notable ingredients complex hallucinations, anger, anxiety, feelings of guilt, remorse, fear, horror with violent reactions; "a peculiar sense of strangeness," compulsive acts; a dreamlike state; tendency to misdemeanors and crimes such as arson, manslaughter, exhibitionism, and he concludes this chapter by stating: "With the passing of the attack, the patient may recall only in a vague sort of way what has transpired. On the other hand, he sometimes remembers with all too vivid a clearness every detail of the attack (this is of forensic importance!)."

More definite yet about the point of memory loss is Perry M. Lichtenstein⁸: "Amnesia for the period of equivalence is the rule." He records variable duration of the equivalent state, absence of convulsive attacks for the period of its occurrence, the automatic or quasi deliberate performance of acts. His views on the subsequent amnesic state are shared by Pilez⁹ with the modification that in protracted instances "the memory defect does not have to be complete but may allow for preservation of lacunary memory mater-

ial." A like opinion is held by Alfred Hauptmann¹⁰.

A rather complex schema has been recently devised by Davidoff, Doolittle and Bonafede¹¹, dealing with the varied mental manifestations in epilepsy. Their discussion, however, is too analytic to satisfy the urgent demand for a more unifying approach. Yet it cannot be denied that their method is an invaluable step toward this goal.

It also should be stated that electroencephalography as a diagnostic method has not contributed absolutely valid criteria to the understanding of this problem. Therefore it will remain up to the clinical observer to arrive at a satisfactory concept that will preclude errors in diagnosis.

Much of the difficulty arises from the vague contours of the psychic seizure syndrome. There is a rather unclear line of demarcation between the psychic epileptic variant and a number of conditions which are liable to produce a similar symptomatology. Other factors of an extraneous nature may enter into the situation to create confusion and obscure the clinical picture. Some of them should be considered here.

The first one is the factor of inherent psychopathy. According to Karl Birnbaum¹², psychopaths may be prone to certain sensorial alterations, and it seems that their resemblance with epileptic phenomena is in the mind of all those who use the classification of "the epileptoid psychopath." In the epileptoid dysphorias, so holds Birnbaum, "inadequate remembrance of single events can often be demonstrated afterward and points to recurring sensorial dimming in the most varied twilight states of the psychopaths."

An important contribution to the understanding of the epileptiform reactions of psychopaths was made by Gruhle¹³. He indicates that in certain psychopaths various sudden disturbances occur just as in epilepsy. To such conditions, he explains, does the term "epileptoid psychopathy" refer, but he insists that "the epileptoid psychopaths are not epileptics." What the former have in common with the latter, and what makes for the designation of epileptoid symptoms in psychopaths, are

(a) endogenous development of symptoms (mood changes, poriomania, dipsomania),

(b) the permanent or varying intolerance to alcohol (often with pathologic intoxication),

(c) the precursory psychopathic symptoms of infancy (prolonged enuresis, pavor).

Gruhle takes a firm stand against attempts at proving a close relation between epilepsy or character changes associated with epilepsy on one hand and psychopathic states on the other, however, he gives us a valuable hint when stating: "One cannot but admit that a clear demarcation of the epileptoid psychopathy from the purely psychic not dementing epilepsy cannot be made, but cases of this type are extremely rare." This difficulty has found an even more adept expression in D. K. Henderson's¹⁴ view: "I am almost inclined to believe that we have widened our conception of the epilepsies to too great a degree, largely because we have had too narrow a conception of what we call psychopathic states. It is not perhaps very important but in certain cases of medico-legal importance we would probably carry much more weight if we showed how a psychopathic state could lead to a state of altered consciousness amounting to an affect and/or psychic epilepsy rather than to try to prove a psychic epilepsy sine fits. The point of difference is that in one case you have a background of a cold, ruthless, impulsive, quarrelsome, explosive person who, on the slightest provocation, will show conduct of an episodic nature without progression of symptoms and without that state of emotional and intellectual deterioration which is so characteristic of the epileptic process. I admit I am not sure of my ground in the above formulation * * * *."

A true counterpart on the organic side is represented by certain reactions in alcoholics, termed the alcoholic twilight states (Heilbronner). These conditions are neither uniform nor clearly understood. They differ from the frank delirious states by their ephemeral nature. Two variants offer themselves for review: the epileptoid type of pathological intoxication and the alcoholic psychoequivalent.

The former was separated from other types by Bonhoeffer and Heilbronner. The latter,

of particular interest to the discussion of the problem of the psychic epileptic variant, has been variously named psychic epilepsy of alcoholic origin *Marchand*¹⁵ and alcoholic psycho-epilepsy *Galant*¹⁶.

Quoting Marchand, psychic epilepsy of alcoholic origin may take the form of migratory automatism with clouding, followed by amnesia. This form should be differentiated from the alcoholic fugue secondary to impelling and terrifying hallucinations without amnesia. Similarly in epileptics, the alcoholic spree will favor the release of migratory automatism. Finally, in epileptic addicts, delirious episodes may occur now of epileptic, then of alcoholic nature. Galant stresses the point that hallucinations, if present, play only a minor role in the alcoholic equivalent states. "The picture is dominated by sensorial clouding, psychomotor unrest, impulsiveness, and violence characteristic of epileptic twilight states."

Naturally, one has seriously to consider the problem of the underlying defect on which such reactions are superposed, as pointed out by Jellinek¹⁷.

On strictly theoretical grounds, it appears imperative that

- (a) the psychic epileptic variant be more clearly and more exclusively defined,
- (b) that more cogent criteria of its differentiation be elaborated,
- (c) that the possible influence of both inherent and exogenous (i. e. toxic, traumatic and other) factors be duly determined by future investigation.

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THE ROLE OF INSUFFICIENT LABORATORY STUDY AND INADEQUATE TREATMENT IN THE DEVELOPMENT OF GENERAL PARESIS

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It is a well established fact that only a small percentage of luetic individuals who never received any specific treatments, fall victims to General Paresis. Of course, the percentage is far greater than among individuals who in the primary and secondary stages underwent intensive planned treatment. Nevertheless, occasionally some luetic in this group eventually become afflicted with neurosyphilis. The question arises as to what is the main factor contributing to this complication.

Many speculations and theories have been presented concerning this problem. For instance, at one time it was considered that intensive treatment with arsenicals was the main cause of this complication. Others thought that a certain strain of spirochete with affinity to the nervous system played a role. Then it was assumed that too small doses of arsenicals made the spirochete resistive. Some physicians tackled this question from the constitutional standpoint and put the main blame on the vulnerability of the nervous tissue, explained by hereditary predisposition.

Possibly some truth is contained in each of these assumptions but from the practical standpoint one has to rely on clinical experience and on the study of case histories. In doing so, one inevitably reaches the conclusion that the most common and most important factor in causing this complication is inadequate study and treatment of lues from the primary infection to the onset of nervous complications.

Any illness responds better to treatment during the initial phase, and the outlook becomes progressively worse with the advance of the process. Any general practitioner who treats lues has to keep detailed records of examination and treatment if he wants to avoid neglect. He has to educate the patients as to what is the cause of his illness, and he has to warn him against possible complica-

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tions. The physician has to practice some psychotherapy in order to create wholesome attitudes toward the problems created by the illness. The individual who becomes ill with syphilis should not rely entirely on the magic of a few "shots" and at the same time fail to readjust his life.

A few case histories with General Paresis will be presented to exemplify this point. One can see that syphilitics in all stages received treatments for years without having had any spinal fluid examination. In some instances the spinal fluid showed definite indication that nervous complications were present but they were entirely disregarded by the physician, and treatments with trivalent arsenicals and bismuth were continued. Ultimately the patient was sent to the State Hospital in a far advanced stage of illness, either quite psychotic or markedly deteriorated. In such cases pentavalent arsenicals and fever therapy were given at the hospital but most of the time the treatments were of no avail.

CASE HISTORIES

1. E. M., is a 40-year-old colored janitor who was committed to the Delaware State Hospital September 18, 1941. At the age of 22 he married, but for some unknown reason he divorced his wife and remarried in 1933. The second wife was of poor reputation and immediately after his marriage he was contaminated with syphilis. He consulted a private physician who found a hard chancre. He was kept in bed for a short time and received a few injections of neoarsphenamine. However, patient soon stopped taking treatments. His physician referred the man to the Board of Health. Patient never received further anti-luetic treatments until his admission to this hospital.

It is interesting to note that patient was under the care of many physicians who considered him neurasthenic. Mentally he was confused, paranoid, suffered with insomnia and was restless. His blood Wassermann was negative, Kahn was negative. Spinal fluid taken 9-24-41: Pressure 30; Wassermann anti-complementary; Cell count per cu. mm. 18; moderate amount of globulin; colloidal gold curve 4445543111.

This case is interesting because there was a definite history of chancre. After patient had

a series of hyperpyrexia treatments and several courses of tryparsamide, he became rational and finally was discharged from the hospital. In this case we see that the patient was ignorant. He did not see the importance of treatments. He had Wassermann tests taken but one was negative, and it was never thought he might have some nervous complication. It is felt that his physician could have enlightened the patient concerning the consequences of neglect. It shows clearly that one should not rely on a negative blood Wassermann alone.

2. The second case shows that the patient never had any anti-luetic treatments and never knew he had lues. His blood Wassermann on admission was negative but he had positive findings in his spinal fluid without distinct neurological findings. His illness started very suddenly with confusion and forgetfulness.

This patient, C. P., a colored laborer, was admitted to this hospital on June 25, 1944, at the age of 50 years. He was married twice, having divorced his first wife 20 years ago. Several days before admission patient suddenly lost all ambition. He could not orient himself as to place, did not recognize people, and while sitting in his own room would make statements that he intended to go home. He did all kinds of queer things, such as chasing chickens in the yard, and then wondered why the chickens would not stay in the chicken coop. Patient's blood Wassermann and Kahn were negative on two occasions. Spinal fluid taken 6-26-44 revealed 160 cells per cu. mm., and strongly positive spinal Wassermann. Colloidal gold curve 5555321000.

This case shows again that one cannot entirely rely on the blood findings. Actually, the spinal fluid should have been examined at any event. We have to admit it is quite rare to find a negative blood Wassermann in complete absence of treatment.

3. F. W., a white woman, 37 years of age, was committed to this hospital on September 11, 1944. Patient was described as a proud and quick-tempered but a little selfish person. In 1924 she married a man with whom she could not get along, and she felt unhappy due to his mistreatment. Her husband ran around with other women, and soon patient

also became promiscuous. This continued until November, 1941, when she obtained a divorce on the grounds of cruelty. In 1939 patient consulted a physician in Wilmington on account of nervousness. Her blood was taken and found to be positive, and she received treatment for one year. At this time her physician was called into service.

She was sent by the doctor to a hospital in Wilmington for a blood examination. From the records at the hospital it was verified that her blood Wassermann and Kline were strongly positive. Spinal fluid was positive. Cell count 10 per cu. mm.; colloidal gold curve was flat. However, she continued to receive neoarsphenamine and bismuth, and altogether she had ten injections of neoarsphenamine and 12 of bismuth from October 7, 1941 to July 7, 1942. She never returned to the hospital and when she was committed to our service she was psychotic, excited and irritable.

Her history reveals that she quarrelled with her sister and even sued her sister because she claimed she owed her money. She was very childish in her behavior, and her conversation was silly. She became grandiose, claimed she had a million dollars hidden in her mother's home. Gait became staggering. In 1940 when driving her car, she had an accident during which her daughter was killed. At another time she was again in an accident and sustained lacerations. Patient had never received any specific treatments from July, 1942, until she entered this hospital. It is interesting to note that she was taken by her sister to a chiropractor who made all kinds of absurd statements in regard to her illness. At present patient is confused and deteriorated and does not respond to any treatment.

This case reveals unrecognized General Paresis over a period of five solid years and a treatment plan that by modern standards must be considered more than inadequate.

4. The following case history will demonstrate the same mistakes:

S. C. was committed to this hospital December 23, 1944, at the age of 39. She got married in 1925. Patient is ignorant and had very little schooling. In February, 1939, she did not feel well and she had a blood test taken by the Board of Health. It was found

positive for lues. It was then suspected that she had cerebro-spinal lues. However, no spinal tap was done. She received 19 neoarsphenamine injections and 26 bismuth salt injections from February 2, 1939, to June 13, 1940. Her treatments were not continued, however. In the spring of 1944 patient started to feel fatigued, suffered from insomnia, started to lose weight, became irritable, restless and paranoid. On admission it was revealed she had positive serological and spinal fluid test results with all neurological symptoms of General Paresis. It seems surprising that, although neuro-lues was suspected, no spinal fluid was ever obtained for examination the results of which would have led to the initiation of proper treatment.

5. E. D., a colored teacher, 37 years of age, married, was committed to this hospital June 30, 1943. Patient displayed psychotic manifestations prior to her commitment for two years. She became careless about her appearance and often walked outdoors incompletely dressed. She neglected her housework. She lost her job as a teacher and changed her position frequently. Her memory became impaired, and there were grandiose tendencies. She would tell her step-mother that she had planned to purchase seven electric fans for her. On one occasion she bought her several bottles of cheap perfume. She would waste her time in movies.

The history revealed that this patient had anti-luetic treatments for 18 months prior to her marriage in 1936. In November, 1942, she took treatments privately and in spite of her change in personality, a spinal tap has never been done. On July 5, 1943, serological tests were strongly positive. Spinal fluid: cells per cu. mm. 48; colloidal gold curve 5553200000; positive Wassermann; globulin 3 plus.

6. Patient W. B., an illiterate colored laborer, 41 years of age, was committed on March 30, 1940, in an agitated, combative state. For two years prior to his commitment he had been nervous and worrisome, and the people who knew him thought he felt bad because he could not find any steady work. He became quarrelsome and he was inclined to be assaultive when he got into an argument. He never cared about religion prior to his illness

but at the onset of his illness he talked only about God and religion. He soon expressed the idea that people were working against him. A month prior to his commitment he was treated by a private physician for heart trouble and "indigestion."

From the social history it was found that patient served a sentence in the workhouse for ten years for manslaughter. During that time he received anti-luetie treatments after his blood Wassermann was found to be strongly positive. In November, 1934, patient underwent an operation in one of the Wilmington hospitals for intestinal obstruction and sub-acute appendicitis. He recovered from this illness promptly, however, his blood Wassermann was not taken at that time. Apparently he denied that he ever had any venereal disease. On admission to this hospital serological tests were very strongly positive. Spinal fluid: 4 cells per cu. mm.; colloidal gold curve 555555443; globulin increased.

7. The following case is interesting because this patient is a very intelligent and cultured person. He was a successful business man and served as private secretary for many years. He was greatly interested in music, literature and the theatre. He was committed to this hospital in 1941 at the age of 52. In November, 1940, patient appeared in a daze and lost his job because of inefficiency. He appeared very weak; was unable to dress himself properly. He had a complete change of personality. On one occasion he started to take his mother to a movie in his car. About two blocks from his home he found that he did not have sufficient gas for his car. He asked his mother to wait in the car while he went for some gas. His mother waited for him for two hours, and he never returned. His mother walked back home and found patient lying asleep on the couch. He could not remember where he had left the car. On one occasion he took his shoes off in the theatre and put them in the aisle. This patient was in a private sanatorium for a short time.

From his history it was verified that thirty years ago he had a primary lesion, and a private physician gave him neosphenamine injections for several months and then told him

he no longer needed treatments. On June 21, 1941, blood Wassermann and Kahn were strongly positive. Spinal fluid: 8 cells per cu. mm.; colloidal gold curve 4555544100.

8. The last case is interesting because about two years ago patient was treated for another illness, however, her blood was not taken and on April 17, 1945, patient was committed to this hospital where a diagnosis of General Paresis was established. This patient, M. B., is a 42-year-old colored domestic who was married twice. She was separated from her first husband seven years. Patient lived with her last husband four years. Her husband drank heavily, and patient left him in January, 1945, and stayed in her mother's home.

Prior to her illness, patient appeared of happy and cheerful disposition. She was gay and had a good sense of humor. Since her illness patient appeared overtalkative, restless and was subject to visual and auditory hallucinations. She insisted that the doctors gave her dope and "syphilis bed." She frequently appeared agitated, threatened and became very untidy. The following report was secured from one of the hospitals in Wilmington:

On December 18, 1942, patient was admitted to their hospital with a tumor of the right forearm. She gave a history of having had generalized tumors of variable size and consistency for the past 37 years. These tumors have been of pea size up to large size, weighing several pounds. The latter ones have been present in the axillary region all the time. Since November, 1942, patient noticed an increase in the size of all tumors. There was no pain or soreness in connection with these tumors. On December 19, 1942, a tumor of the right forearm was removed, weighing approximately 10 pounds. Pathological diagnosis: Elephantiasis Molluscum. Patient was discharged with a diagnosis of Recklinghausen's Disease.

Upon admission to our hospital there was still all the evidence of Recklinghausen's disease; nevertheless, patient had typical neurological findings of General Paresis such as overactive knee jerks and Achilles reflexes, a marked tremor of the outspread fingers and of the protruded tongue. She had some slur-

ring on test phrases. Pupils were markedly enlarged and did not react to light. In Romberg position patient swayed to the left. Her blood Wassermann and spinal serology were positive for neuro-syphilis.

A series of eight cases of General Paresis are presented to demonstrate failures of examination and treatment. All of these patients excepting one knew that they had syphilis. Only one of these patients had a spinal fluid examination prior to entrance to this hospital. Three of these patients showed a definite change in personality for several years, nevertheless, they never had spinal fluid examinations. One patient who had positive spinal fluid findings continued to receive trivalent arsenicals, but no attention was paid to her nervous complications.

It is obvious that spinal fluid examinations are indicated in any case of syphilis regardless of the actual phase of the illness, and especially in untreated or inadequately treated cases. There is a particular need for picking up cases at the so-called latent phase of neuro-syphilis when the spinal fluid examination is apt to reveal definite changes in the absence of other clinically demonstrable symptoms as this is precisely the phase at which, with adequate treatment, nervous complications can be forestalled with a fair degree of certainty.

It is to be regretted that in spite of the common experience presented by the cases advancing toward the active phase of neuro-syphilis, especially those of General Paresis, there are still too many victims of plain negligence in this group of patients. Although we do not wish to blame the situation on any individual, be it patient or physician, it is indispensable that a condition which is readily accessible to diagnosis and cure, be brought to light by the simple procedure of the spinal tap and by routine spinal fluid laboratory examinations.

DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS IN A CASE OF POST-INFECTIOUS PSYCHOSIS

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The case presented here is one of an acute psychotic episode caused either by an infectious disease or the drugs administered at the

time of the patient's illness. The patient was admitted January 18, 1945, and paroled February 17, 1945. The admission papers stated that this man suffered from disorders of memory and incoherence. He was careless in regard to clothing and furniture. About two weeks before admission he had an attack of what was probably pneumonia and was treated with sulfa drugs. Ten days before admission he began to be restless, forgetful and fretful. Later he became disoriented as to time and place but not people. He was admitted to a convalescence home on January 15th but would get ready to go to work. It was from this home that he was committed to the State Hospital.

On studying the case it was found there were no nervous or mental diseases on either the paternal or maternal side of the family with the exception of one brother, now deceased, who had been a patient in this hospital many years ago suffering from a toxic psychosis. Patient was born in Delaware 67 years ago. He graduated from the Wilmington High School. For a while he was an actor for a company that travelled and produced plays in different towns. After his marriage in 1906 he worked for the Electric Hose and Rubber Co., then the Bell Telephone Co. After this he was employed as secretary to the Warden of the New Castle County Workhouse, maintaining this position until the new Warden was appointed. At this time he was assigned to the commissary department. He worked at the Workhouse for ten years. In 1942 his wife died and patient went to Hollywood, California, on two different occasions, both times working in the properties department of the Warner Bros. Studio. Since May, 1944, he has worked as clerk at the Pyrites Co. There are two daughters who are both in good physical and mental health.

The patient himself was always considered sociable and friendly and a man who was easy to get along with. He had numerous hobbies and was particularly interested in current events. He was a member of the Masons in good standing. He is described as being inclined to be nervous and much of his activity was due to this nervous energy. His medical history had been good and he had never been seriously ill with the exception

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he might have had "brain fever" as a child. However, no definite information could be obtained about this. For a while he attempted to establish a home for his daughters but they married and he was forced to live alone. He disapproved of both his daughters' marriages but did not make a satisfactory emotional adjustment to a solitary life. Habits were relatively good and he never used alcohol but was inclined to smoke rather heavily.

On January 6th, about two weeks before his admission to this hospital, he became ill with a lung condition diagnosed as either grippe or pneumonia. At this time his temperature was elevated to 103 degrees and he was treated with sulfa medication. During his illness and since he had been very drowsy and confused. Also during the acute stage of his illness he was delirious. On January 14th he was removed to a convalescence home but they were unable to keep him as he was still somewhat confused and disturbed the other patients. For this reason he was transferred to the Delaware State Hospital.

Physical examination showed the patient to be a 67-year-old man of asthenic habitus in a somewhat dehydrated and emaciated condition. Skin was dry and teeth covered by sores. The heart was normal in size, shape and position. No murmurs were detected and the action was regular. Blood pressure was 140/80. There was some evidence of sclerotic changes in the blood vessels. The muscles of the chest were atrophied but no lung pathology could be found. The abdomen was somewhat distended, particularly in the bladder region. Neurologically the patient appeared fatigued and rather drowsy. Examination of the discs showed a slight tortuosity of the vessels. The deep reflexes were exaggerated. The abdominal reflexes could not be obtained. Laboratory examination showed a slight increase in leucocyte count. On one occasion albumin was found in the urine but blood urea remained in the upper normal level. Blood and spinal fluid Wassermanns were negative. Blood sugar ranged from 88 to 104. On admission it was necessary to catheterize him but later he voided spontaneously. The following day he again had some urinary retention although no abnormality of the prostate

gland or structure of the urethra could be found. Eventually a retention catheter was inserted but in a few days he had no further difficulty and was voiding spontaneously.

Mentally on admission he appeared drowsy and his answers to questions were considerably delayed. He was oriented as to person and superficially seemed to be coherent and relevant. However, on closer questioning he was found to be disoriented as to place, thinking that he had been taken to a hotel or the second floor of the Wilmington Trust Company. The same evening he appeared more alert and realized he was at the Delaware State Hospital. The following day he was again slightly confused, showing numerous gaps in memory. He was unable to state how and when he was brought to the hospital nor did he know where he had spent the time during the past week. Two days following admission he gave a fairly accurate account of the happenings before his admission but still had a partial retrograde amnesia. However, he was cooperative, friendly and polite.

On the third day after his admission there was very little evidence of mental clouding and he was in excellent contact with his surroundings. Temperature, which had been elevated on admission, dropped to normal. Within a week there was no evidence of psychosis. Psychological examination showed that verbal functions were of superior development. He often enriched definitions with good-natured comments. Responses to information tests indicated a well-rounded intellectual interest. There was some tendency toward forgetfulness and the application of his native ability was low. However, the test was done under adverse conditions when the patient was physically exhausted and weak. He was considered to be of superior native intelligence and remarkably well preserved but showed some decrease in immediate memory and in processes involved in meeting new problems.

It seems to be evident, judging by his spontaneous and rapid recovery, that patient's psychosis was apparently caused by either toxic reaction due to his illness or by the medication he had received. There are in the literature instances where patients showed psychotic manifestations even after small

doses of sulfa drugs but, as in this case, no blood level for sulfa was established, it cannot be accurately stated that his mental derangement has been due to this drug. On the other hand, as we know that many acute infectious diseases often go hand in hand with psychotic manifestations, it was safer to diagnose him as post-infectious psychosis. Nevertheless, the medication might have played an additional role, therefore it seems always wise to watch and be on the alert for mental symptoms, which might be due to this additional factor.

RELIGIOUS-SEXUAL EXCITEMENT SYNDROME IN THE CASE OF A SCHIZOPHRENIC MINISTER

F. A. FREYHAN, M. D.,*

Farnhurst, Del.

The following case is presented because of its rather unusual social and psychiatric implications. A minister, M. B., 32 years of age, of excellent personal reputation, who is in charge of a congregation in a small town in Ohio, develops gradually psychotic symptoms of religious character which remain unrecognized for a long time because they are taken as manifestations of his religious philosophy. He continues to exercise his duties as a leader of his parish although he has undergone a tremendous personality change and bizarre religious and sexual delusions begin to dominate his thoughts and actions.

On January 15, 1945, this patient arrives in Wilmington, Delaware, in order to visit his sick mother who lives in the home of a lady who is a family friend. He stares at his mother for a long time then begins to pray and asks the lady of the house to do likewise. He orders her to kneel down so as to pray with greater devotion. Suddenly he becomes excited and restless and mumbles to himself, then puts his arms around the kneeling woman, throws her on a couch and attempts to assault her sexually. She fights him off and pushes him out of the room, whereupon he grabs his suitcase and runs out of the house. Mumbling to himself he runs down the street, stops at the corner grocery store where he throws vegetables and canned goods all over the floor. When the grocer calls the

police, he runs across the street to a churchyard, disrobes completely and throws his clothes on the street. The police officers arrive to arrest him. He struggles violently and mumbles "The Lord told me to do so. When I see red, I don't know what to do. I had to get the devils out." He was immediately committed to the Delaware State Hospital.

During the admission procedure patient appeared very preoccupied, stared as in a daze and refused to talk. Patient was taken to the admission ward and he immediately became excited, danced around in the nude, attempted to masturbate and used very obscene language. It became necessary to restrain him as he fought everyone entering his room. He ordered the nurses out of his room because he could not see anything red such as the red sweater worn by one nurse and the color of the lipstick of another nurse. When seen the next morning, he sang continuously, "Peter Rabbit went to town riding on a poney" and he went through the motions of riding while singing. His conversation was entirely within the realm of sexual obscenities but he also expressed some grandiose ideas such as "Get out of this room, I built it, I paid for it, my children will inherit it!"

Physical examination revealed him to be a tall, well developed man of leptosome habitus. Examination of internal organs as well as neurological examination did not reveal any significant findings. Laboratory tests including blood counts, urinalysis, blood and spinal serology were all within normal limits. Electro-shock treatments were started immediately. Patient quieted down considerably after his first two convulsive seizures and began to talk more coherently. Utter perplexion overcame him when he realized what had happened to him. Again and again he exclaimed, "What did I do? How could I do such a terrible thing?" Invariably he added, "I knew all the time what I was doing but I had to obey the voice of the Lord." His attitude became rather submissive and he seemed completely at a loss to understand himself.

A few days later he again became suddenly disturbed and broke all the window panes in his room. When he was asked why he did that, he stated that the Lord told him

* Assistant Physician, Delaware State Hospital.

he might have had "brain fever" as a child. However, no definite information could be obtained about this. For a while he attempted to establish a home for his daughters but they married and he was forced to live alone. He disapproved of both his daughters' marriages but did not make a satisfactory emotional adjustment to a solitary life. Habits were relatively good and he never used alcohol but was inclined to smoke rather heavily.

On January 6th, about two weeks before his admission to this hospital, he became ill with a lung condition diagnosed as either grippe or pneumonia. At this time his temperature was elevated to 103 degrees and he was treated with sulfa medication. During his illness and since he had been very drowsy and confused. Also during the acute stage of his illness he was delirious. On January 14th he was removed to a convalescence home but they were unable to keep him as he was still somewhat confused and disturbed the other patients. For this reason he was transferred to the Delaware State Hospital.

Physical examination showed the patient to be a 67-year-old man of asthenic habitus in a somewhat dehydrated and emaciated condition. Skin was dry and teeth covered by sores. The heart was normal in size, shape and position. No murmurs were detected and the action was regular. Blood pressure was 140/80. There was some evidence of sclerotic changes in the blood vessels. The muscles of the chest were atrophied but no lung pathology could be found. The abdomen was somewhat distended, particularly in the bladder region. Neurologically the patient appeared fatigued and rather drowsy. Examination of the discs showed a slight tortuosity of the vessels. The deep reflexes were exaggerated. The abdominal reflexes could not be obtained. Laboratory examination showed a slight increase in leucocyte count. On one occasion albumin was found in the urine but blood urea remained in the upper normal level. Blood and spinal fluid Wassermanns were negative. Blood sugar ranged from 88 to 104. On admission it was necessary to catheterize him but later he voided spontaneously. The following day he again had some urinary retention although no abnormality of the prostate

gland or structure of the urethra could be found. Eventually a retention catheter was inserted but in a few days he had no further difficulty and was voiding spontaneously.

Mentally on admission he appeared drowsy and his answers to questions were considerably delayed. He was oriented as to person and superficially seemed to be coherent and relevant. However, on closer questioning he was found to be disoriented as to place, thinking that he had been taken to a hotel or the second floor of the Wilmington Trust Company. The same evening he appeared more alert and realized he was at the Delaware State Hospital. The following day he was again slightly confused, showing numerous gaps in memory. He was unable to state how and when he was brought to the hospital nor did he know where he had spent the time during the past week. Two days following admission he gave a fairly accurate account of the happenings before his admission but still had a partial retrograde amnesia. However, he was cooperative, friendly and polite.

On the third day after his admission there was very little evidence of mental clouding and he was in excellent contact with his surroundings. Temperature, which had been elevated on admission, dropped to normal. Within a week there was no evidence of psychosis. Psychological examination showed that verbal functions were of superior development. He often enriched definitions with good-natured comments. Responses to information tests indicated a well-rounded intellectual interest. There was some tendency toward forgetfulness and the application of his native ability was low. However, the test was done under adverse conditions when the patient was physically exhausted and weak. He was considered to be of superior native intelligence and remarkably well preserved but showed some decrease in immediate memory and in processes involved in meeting new problems.

It seems to be evident, judging by his spontaneous and rapid recovery, that patient's psychosis was apparently caused by either toxic reaction due to his illness or by the medication he had received. There are in the literature instances where patients showed psychotic manifestations even after small

doses of sulfa drugs but, as in this case, no blood level for sulfa was established, it cannot be accurately stated that his mental derangement has been due to this drug. On the other hand, as we know that many acute infectious diseases often go hand in hand with psychotic manifestations, it was safer to diagnose him as post-infectious psychosis. Nevertheless, the medication might have played an additional role, therefore it seems always wise to watch and be on the alert for mental symptoms, which might be due to this additional factor.

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A few days later he again became suddenly disturbed and broke all the window panes in his room. When he was asked why he did that, he stated that the Lord told him

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to do so. He interpreted this command as a means of getting transferred to a disturbed ward. This would mean the lowest degree of humiliation and then God would recognize him as his own son and liberate him through a miracle. Shock treatments were continued on a daily basis and patient became increasingly cooperative and talked with better insight about his situation. His conduct and attitude on the ward became more normal and he made a good ward adjustment; however he remained preoccupied and unrealistic. Constant reassurance was required as patient apologized again and again for his past behavior.

During the first week of March his behavior again changed. He stared into space and imagined that the Lord was talking to him about his future. One day he suddenly stripped completely nude, ran after a student nurse, embraced and tried to assault her sexually. While doing this he repeated over and over again. "The Lord tells me to do this. I have to obey the Lord's voice." Following this incident he became very disturbed, talked obscenely about the genitals of the personnel attending him, assaulted the male attendant in a state of sexual excitement and then suddenly went into a state of stupor, knelt on the floor for hours, refused to talk and to eat and stated merely "God told me to fast for three days and three nights." It became necessary to tube feed patient. He had to be secluded because of his assaultive tendencies and he was finally transferred to another state institution in his own state. This transfer again caused great difficulties in management. He was uncooperative on the train and, in spite of all precautions, became suddenly excited after leaving the train at the railroad station in Columbus, Ohio, where he tore his trousers off and became vile.

Case Analysis: Patient had been socially well adjusted as a young man and student. He was very studious, did quite well in school and entered a missionary school at the age of 17. After his graduation he became a minister and for the last three years had been in charge of a parish in a small town in Ohio. About ten years ago he married. There are three children, 8, 5, and 1 year

of age. Married life has been congenial and happy.

Patient difficulties began when he became aware of discrepancies between his dreams and hopes for success and the lack of materialization of his desires. Although he was usually cheerful and mild mannered and got along well with people, he was an introspective type of individual who wanted to impose his own ideas upon others. Somehow he had developed the idea that a television church should be founded and he began to discuss this plan with various high officers of his church organization. While these ideas were not altogether unrealistic and although he explained that television was the thing of the future, it actually was to be the basis for his way to fame. He became more and more preoccupied with the details of this plan and he saw himself as the first minister of the "American Television Church." He began to practice his voice, became conscious of his movements, bought expensive clothes that he could not afford and prepared himself in every way for his important role. On at least two occasions he locked himself in his room and prayed continuously for three days and nights. His attitude, although peculiar, was taken as manifestation of his religious philosophy.

His sexual activities were restricted. He believed that two sexual intercourses a week were the maximum that a man could afford without losing his physical strength. Whenever he overstepped this limit he worried a great deal and consulted various physicians for advice. Finally he stated, "God helped me and made me strong and healthy." Patient's wife stated that patient often could not sleep at all on account of disturbing erections yet he refused to find relief from sexual tension because this would have been against his "understanding with the Lord."

It is interesting to observe how this minister became increasingly unrealistic. He felt that he was close to the Lord and that he could become a prophet. His delusions and auditory hallucinations, it appears, were not interpreted as psychopathological phenomena because of the religious content. The onset of the acute psychotic phase came with explosive and lightening-like rapidity. In-

hibitions and repressive forces ceased to function and patient now lost all contact with reality.

There can be no doubt that we deal with a schizophrenic type of psychosis. It is not believed that this psychotic reaction can be explained as a result of a maladjustment to the situation of social and sexual frustration. The disturbance is deeper and more fundamental. It is believed that patient's desire to become a minister was determined by autistic motives. He was not so much concerned with interpreting God's word to the people as with his personal relationship to God from which he expected a mystic transfiguration. His sexual excitement fits into this scheme of thought in as far as humiliation would make him eligible for "the miracle of liberation."

It is not the aim of this paper to engage in an exhaustive psychiatric analysis of the psychopathological phenoma. It is only intended to show how gradual the onset of a major psychosis can be and how important it is to recognize an abnormal attitude from the very beginning if severe consequences are to be avoided.

THE TREATMENT OF EXPRESSIVE APHASIA IN A WAR VETERAN

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The patient under consideration was 20 years old when he enlisted in the Seabees in November 1943. A month later, while in training camp, he suddenly became ill, fainted and fell on the floor of the barracks. He was treated for "cat fever" at the base hospital. Lobar pneumonia affecting the right lung developed shortly thereafter. On December 28, 1943, he was transferred to a Naval Hospital where he developed paralysis of the right side with almost complete loss of speech and other language functions. Brain abscess, secondary to pneumonia, was suspected. Four months later he was moved to another Naval Hospital where cerebral hemorrhage due to fall was regarded as the possible cause. He was discharged from the Navy and returned to his home on June 9,

1944, in a somewhat improved condition. There was partial recovery of the function of the right leg so that he was able to walk with the assistance of a cane. His language disturbances have shown some slight improvement. As he was unable to make a normal adjustment to his home and work, he was referred by his family physician to the Mental Hygiene Clinic for psychiatric guidance and for advice concerning his vocational and social rehabilitation.

Personal and Social History. Our patient left school at the age of 17 shortly before completing the 11th grade. At school he was an unambitious scholar, irregular in attendance and often tardy, being known as a "10 o'clock scholar." As an adolescent he required more sleep than the average boy. He went to bed early and slept late the next morning. He married almost immediately after he quit school. Two children were born up to the time of his enlistment. His family life was, according to his wife, characterized by selfishness, extreme jealousy, stubborn wilfulness and excessive sexual demands. He threatened to return to his mother whenever things did not come his way. After his discharge from the Navy he lost all sense of responsibility toward home and family. He liked to wander about town aimlessly and resented suggestions that he might be helpful about the house or accompany his wife on her shopping trips or on walks with the children. His wife separated from him late in 1944. Subsequently she obtained a divorce decree on grounds of extreme cruelty.

The patient's early childhood was normal in physical and mental development. He was a finicky eater, complaining that certain foods gagged him. He was indulged in by his mother who always prepared special meals for him when he was displeased with the regular family menu. He was subject to falls and accidents, sustaining a head injury at the age of 5, a broken arm at 10, a broken right ankle at 13, and a severe knee injury with unconsciousness at 16. He smoked about one package of cigarettes a day since the age of 13. Prior to his enlistments he drank large quantities of beer often to the point of intoxication.

Between 1941 and 1943 he worked in three

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different defense plants, earning up to \$60 a week.

Physical Condition. General physical development is satisfactory. There is a small star-shaped scar on the right side of the forehead. There is spastic paralysis of the extremities on the right side. He is able to walk by hyper-extending the right knee so that the right leg will sustain his weight. He uses the right leg as he would use an artificial limb. There is marked resistance to extension of the forearm. The right arm is otherwise inoperative. The tendon reflexes on the right are very much exaggerated. Ankle clonus is not obtained. The tongue deviates slightly to the right upon extension. Facial musculature has almost normal motility. Both eyelids are closed readily with some tremor on the right side. The examination of eye-grounds is negative. He complains of impairment of vision in the left eye. With the exception of the direct sequellae of the brain injury in the region of the left motor cortex, there appears to be no mental disturbance classifiable as a psychosis.

Personality Analysis. The patient had two psychometric examinations, the first on June 28, 1944, the second on April 21, 1945. The numerical results expressed in terms of standard scores for persons of his age are as follows:

Nature of Test	Standard Scores *	
	June 1944	April 1945
Word Definitions ... not given		69
Oral Reading	29	29
Verbal Analogies ... not given		42
Picture Anomalies ..	103	94
Picture Reasoning ..	79	79
Digit Recall Series ..	16	24
Mental Arithmetic ..	45	50
Symbol Substitution	54	not given
Reproduction of Drawings	83	88
Multiple Form Boards	91	99

The psychometric results yield extreme discrepancies between the various abilities. They no doubt reflect the intra-individual difficulties of adjustment created by the cerebral trauma. Apparently some mental functions

have remained intact, while others have suffered serious damage. The ratios of the lowest to the highest standard scores are 15 for the first test and 24 for the second. The average ratio is 75. Ratios below 60 are indicative of severe personality deviations or behavior inadequacies. Large differences between tests reflect not only the degree of personal maladjustment, but also the potentialities for reeducation. The defective functions are usually capable of improvement until they have reached, at least theoretically, the level of the highest or least damaged function. In this case there is evidence of much damage and also much room for betterment. Had the highest test scores been lower than they are the outlook for retraining would be considerably dimmer.

The most consistently serious impairment has occurred in the sphere of language and related aptitudes. The motor skills have also been greatly affected. Thinking processes depending on the arrangement of ideas in arbitrary sequences are markedly disturbed. This is a common finding in organic cases with or without aphasia. The surprising rating is the very defective recall score. The patient seems to be more adequate in the repetition of words and brief phrases than he is in the voluntary and spontaneous use of speech. His articulations are unimpaired except when the words are complicated and relatively unfamiliar. Yet the recall series accurately measures his dangerously low attention span for auditory perceptions. This disability is predicated partly on the direct perceptual losses and partly on the broader disorganization wrought by the illness. It is likely that the patient's volitional traits have not been normal to begin with and that the present reduction is the combined result of original dysfunctioning and acquired handicap. The loss of drive and perseverance is of course the greatest obstacle to recovery.

Within the verbal sphere the reading functions have suffered the severest loss. He recognizes the capital letters A and B, nothing else. He identifies letters and words accurately when they are presented to him singly in order to be picked out of some printed context. He writes his name with the left hand which he has learned to use with mod-

* Standard scores of 90 to 110 indicate average ability; 80 to 89 low average; 70 to 79 inferior; 50 to 69 defective; below 50 very defective.

erate effectiveness. He likes to copy words which he understands but cannot name. Loss of writing and spelling is less serious than reading, but his functional achievement does not exceed the first grade level. There is no significant difference between the results of the reading and writing tests of the first and second interview 10 months later. The voluntary employment of speech is materially higher than are the mechanics of reading and writing. Expressive speech occurs in characteristically broken fragments in agreement with the reduced concentration span. Emotionally colored expressions are more facile than objective descriptions. At no time does he use longer than three-word phrases. Pronouns and recently acquired names of frequently seen persons offer the smallest difficulties. He is able to name a few common articles but not without much strain and effort. He learns the names of previously unnamed objects during the test interview and remembers some of them two hours later. The ability for verbal abstraction is interfered with by the concreteness, specificity and the very narrow range of his verbal experiences. He associates the word "table" with the specific object referred to in teaching, but does not recall the name when the picture of a table is shown him. This difficulty may well be related to the broader reasoning deficit mentioned before. The comprehension of spoken language is the best preserved aptitude of the total language pattern. Because of the limited mental focus the grasp of lengthy verbal directions is distinctly below average. However, the comprehension of relatively abstract and mature concepts presented in piece-meal fashion is entirely satisfactory. Brief verbal commissions are carried out faultlessly. Even such abstract terms as "taste, then, prompt" are readily understood and well-defined. Here again, the narrow span rather than the inability to grasp abstract meanings is the major interference. The maturity level of his verbal comprehension is average in comparison with adult norms. Impairment of verbal synthesis is apparently controlled by the organizational phases of the personality rather than its capacitive altitude. The patient has lost most of his arithmetical concepts except mechanical

counting. He is unable to name the number of objects without first counting them. All time and number relations in daily use have disappeared. He cannot tell the time. He does not know the day of the week, though he can name the days of the week with some help. The concepts of "yesterday, tomorrow, next week, last month" offer almost insuperable obstacles in verbal expression. He cannot tell his birthdate, but is proud of himself when he remembers it at the end of the interview after being told. Simple additions and subtractions are done tardily and inaccurately. When he is allowed to write the numbers down on a piece of paper, he calculates with somewhat better results. His computation ability is comparable to that of the average child entering the second grade. There is stubborn persistence of preceding upon subsequent impressions, especially in auditory recall.

Those aspects of behavior which approximately reveal his native capacity relate to contacts with the objective and concrete environment and to the comprehension and application of spatial abstractions to practical issues. His sense of space is normal. Directional orientation is well preserved. He detects complex picture anomalies with average speed and good emotional rapport. Drawings are remembered and reproduced with fair accuracy at the lower levels. As the demands upon attention become greater he simplifies the designs in comparison with the models. Strangely enough, perseverations such as are observed in his recall and verbal productions are absent from all pencil work. His lines are firm, moderately straight and well-organized in relation to each other. Meaningful patterns are recognized even in designs which are poorly reproduced. A certain degree of inflexibility and a strong tendency to discontinue his job are observed even in the most successful performances. His will to accomplish things is diminished. He depends on others and does not exert himself sufficiently for uniform and unqualified success. Encouragement has no lasting effect. Avoidance reactions become pronounced and insistent at exacting test levels. It is clear that his native endowment has been and still is average, that his illness has caused severe

disorganization in addition to the speech impediment.

The repeat psychometric study discloses an almost identical functional pattern. Within a period of eleven months there has been no appreciable change in his general mental state for better or for worse.

Treatment. The recommendation was made that the patient be referred to the Veterans Administration for further treatment and possible vocational rehabilitation. After several unsuccessful attempts had been made to arrange for treatments at a government hospital or clinic, the patient was again referred to the Mental Hygiene Clinic for a reanalysis of his speech condition and occupational future. Several jobs were found for him during the period between the two examinations, but he could not hold them because they required normal speech and reading. The second study was made with the view of providing local opportunities for the treatment of his aphasic condition. A private teacher experienced in the treatment of aphasic speech was found and regular training sessions were instituted on a cooperative basis between the local Bureau of Vocational Rehabilitation, the speech teacher and the State Mental Hygiene Clinic.

The investigations by Head, Goldstein, Weisenburg and McBride constitute important exploratory groundwork upon which further systematic progress in the study and treatment of aphasia must be based. Past experiences concerning the outcome of speech retraining of aphasic patients are not especially encouraging. Spontaneous recoveries following the subsidence of acute neural disturbances are far more dramatic than is the methodical and protracted treatment of the chronic condition. However, there is practically always a temporary improvement in the personal morale of the patient along with limited gains in the mastery of speech. The chances for a complete restoration of previously possessed abilities are believed to be small. The evaluation of gains resulting from speech therapy has so far been largely subjective. The number of cases studied under rigorous conditions and according to consistent criteria of comparison are so few that no conclusive evidence about the prog-

nostic outlook one way or another has been reported. The duration of the active retraining periods is in many cases too short to enable the teacher or the physician to judge the end results adequately. It takes the average child approximately six years to acquire a passable mastery of speech. Aphasic patients are often considered failures after training periods of only three or six months.

Despite the tentative nature of our knowledge of aphasia and its effective treatment, certain general rules seem applicable to most cases. The proper treatment must be based on a thorough analysis of the individual disturbance. Aphasia has many facets and degrees. The inherent and modified personality of the afflicted patient is not to be disregarded. Speech is an integral part of the whole individual. It cannot be taught as a mechanical process apart from the complex behavior pattern to which it belongs. The unknown is usually built upon the intact apperceptive background. The difficulty and the range of the subject matter depends on the extent of the damage and on the degree of ability still present. The errors of organic speech disturbances bear a striking resemblance to the errors encountered in young children learning to talk, read, and write.

Nature spontaneously provides mental crutches which enable the personality to survive in critical emergencies. Aphasia as an adjustment problem is no exception to the rule. Learning crutches are not to be dismissed lightly. In fact, the teacher must be constantly on the look-out for these self-help measures which ease the patient's learning difficulties to a considerable extent. They must be taken advantage of as long as they are helpful. They are usually discarded after having accomplished their purpose. Indirect and round-about procedures of teaching are legitimate when they achieve results which would otherwise be unattainable. The lesson contents must be simple, practical, concrete and meaningful. They should develop self-reliance in the particular environment in which the patient lives. Teaching proceeds from the simple to the complex, from the concrete to the abstract. Spontaneous interests may be employed to foster secondary interests

which alone can strengthen the patient's volition and insure real progress.

Our patient is a young man of average intelligence. The after-effects of his cerebral illness are so disabling that a normal social and occupational adjustment in his present state is out of the question. The outlook for a more acceptable turn of events by positive retraining is not unfavorable. His speech can be greatly improved. Even if it takes two years to increase his word knowledge by three or four hundred words, it may spell the difference between a fairly normal life and total failure. The functional vocabulary of the average adult is only about 700 words. Half of this average together with a limited command of the numerous syntactical combinations may constitute a worthy goal of our teaching program.

The provisional schedule contains the following recommendations.

(1) The optimal distribution of learning periods is one hour daily for six days a week.

(2) The patient establishes a fair-sized vocabulary by learning the names of common objects and events. The naming exercises are limited to concrete things in daily use such as pieces of furniture, body parts, clothing, foods, and human activities. The naming of pictures may be used interchangeably with the naming of their objective counterparts. This may develop the diminished ability of generalizing or abstracting. The drills are repeated until the name is given without undue conscious effort. Emphasis on thoroughness and ready use is preferred to stress on quantity. The newly learned concepts and names are listed for future reference.

(3) Brief descriptions of simple actions and articles may be practised along with the vocabulary exercises. For example "What is this?" A. "This is a book." Q. "What are books for?" A. "We read books." Q. "What are books made of?" A. "They're made of paper." Q. "How many pages has this book?" A. "245.", etc. . . . This procedure may be used with every article which is readily named. The questions should not require complex answers. Here again, constant drill in the complete mastery of a few practical phrases is better than the superficial and speedy treatment of many.

(4) The patient learns to tell the time with the help of a demonstration watch. He learns to count objects reliably up to 100 and practices to name the number of objects shown to him up to five. Pennies, fingers, chairs, pencils and other articles may be used for this purpose. Current coins and paper money are to be relearned. They may also be used to restore the naming and the proper application of ordinary number relations. Recognition and naming of numbers in print is important. The naming of time relations is taken up early in the training period. What day is it today? What day of the week was yesterday? Tomorrow? What month is it now? Next month? Last month? What year is it? Is this morning or afternoon? What follows day? etc. . . .

(5) Finally, reading and writing may be taught. It is not believed that these will be easily restored. They may be tried after some progress has been made in spontaneous conversation. Writing, copying and tracing may be helpful mnemonic devices in building up associative links in the motor pathways.

The patient is generally attentive and well-motivated as long as the task does not strain him too much. The danger of doing too much at one session is greater than of doing too little. He perseverates strongly if different exercises follow one another too rapidly or if the unit is too large for his mental span. Therefore frequent repetitions and intermissions of a few seconds between succeeding stimuli are desirable, particularly during the first few weeks.

It is too early to evaluate the progress of the remedial work just begun. The patient has learned a dozen new words during the first week. He is elated over the prospects of learning to talk. Above all, he is acquiring a technique of helping himself. He is beginning to use new words and new phrases of his own accord. His parents report that he now expresses his desire for certain foods for breakfast, lunch and dinner. He greets people and enters into simple conversation which he never did before the corrective measures had been undertaken.

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MISCELLANEOUS

Extracts May Give Protection Against The Rash of Poison Ivy

A.M.A. Council on Pharmacy and Chemistry Advises, However, That They Should Not Be Used in Treatment of Condition

People sensitive to poison ivy can be desensitized temporarily by the use of poison ivy extracts, but these preparations should not be administered for the treatment of the skin inflammation due to poison ivy, the Council on Pharmacy and Chemistry of the American Medical Association reports Franklin A. Stevens, M.D., New York, prepared for the Council a review of the status of poison ivy preparations which appears in *The Journal of the American Medical Association* for April 7.

Ivy dermatitis, the skin inflammation due to poison ivy, Dr. Stevens says, "is a self-limited disease of short but indefinite duration with variable symptoms, and no satisfactory evidence has been brought forth to show that the course has been changed for the better by this therapy (treatment). Since it is known that many patients are made worse because severe reactions occur when large doses of extracted solids are injected and since the practice is not in conformity with theory, it is believed that the treatment of acute ivy rashes either parenterally (by injection) or orally (by mouth) with ivy extracts should be vigorously discouraged. . . ."

More than fifty species of poison ivy, oak or vine have been described as native to North America, but only three of these, classified as *Toxicodendron*, are described by conservative botanists and accepted by the United States Herbarium in Washington, D. C. Poison or swamp sumac has also been included in this classification as a species of *Toxicodendron*. Since the chief point of differentiation has been the shape of the leaflets, which vary greatly in contour in various plants and sometimes in the same plant of any of the species, it is not surprising, Dr. Stevens indicates, that so many species have been described. The terms "poison vine," "ivy" and "oak" have been used to describe plants of any species if they had vinelike or shrublike characteristics or had a tendency to grow like

a tree. On the other hand the term "poison oak" is also used to designate certain species with indented oaklike leaves.

The poisonous substance in at least one species of ivy has been identified chemically as urushiol. It had been determined as the active factor in the sap of the lac trees of Japan, China and Indo-China. The chemical properties of the poisonous substance which has been isolated from the other species of ivy or oak and from swamp sumac are such that it is very probable that urushiol is the irritant common to ivy, sumac and the lac trees. Since evidence garnered from the study of the human resistance to this particular poison supports this view, it is believed that a single extract can be used in any attempted prophylactic treatment for the dermatitis caused by any one of these plants.

Dr. Stevens points out that all observers believe the typical dermatitis is the result of contact after previous exposure and sensitization to the active substance in the plants. It is possible to sensitize an individual with the plant extracts or with urushiol. There is also some evidence that this sensitization resulting from either experimental or natural contact decreases in intensity if not maintained by repeated exposure.

He reports that all the chief races appear to be equally susceptible if they have been equally exposed. Investigators have obtained almost identical percentages among adult white subjects and American Indians living west of the Mississippi River. One racial exception so far encountered is the Eskimos on Baffin Island, none of whom reacted to tests with ivy extracts.

Dr. Stevens states that "Persons who show strongly positive skin tests with ivy extracts and are susceptible to the dermatitis can be rendered dermally insensitive to the test and also resistant to rigorous exposure to the plants by the daily ingestion of large increasing doses of ivy extracts. All the evidence suggests that these subjects are desensitized rather than immunized, but unfortunately most are only temporarily 'resistant' or 'protected' against ivy. If the period of ingestion is short, that is six weeks or less, the doses of extract required to accomplish 'desensitiza-

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+ Editorial +

DELAWARE STATE MEDICAL JOURNAL

Owned and published by the Medical Society of Delaware, a scientific society, non-profit corporation. Issued about the twentieth of each month under the supervision of the Committee on Publication.

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Articles are accepted for publication on condition that they are contributed solely to this JOURNAL. Manuscripts must be typewritten, double spaced, with wide margins, and the original copy submitted. Photographs and drawing for illustrations must be carefully marked and show clearly what is intended.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus, published by the American Medical Association, Chicago.

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Subscription price: \$2.00 per annum, in advance. Single copies, 20 cents. Foreign countries: \$2.50 per annum.

VOL. 17

MAY, 1945

No. 5

A CHALLENGE

We are cognizant of the fact that the attention of the entire Nation has been focused upon the need for adequate preventive and curative mental health services, for all of the people, and that there is a definite demand for such hospital and out-patient services within the means of all classes of society.

American Psychiatric and American Medical Associations will have a great opportunity in the post war period to wage a total war against the early twentieth century methods of the care and treatment of the mentally ill, to change the concept of the people in regard to psychiatrists as well as psychiatric hospitals.

This can be achieved only through the creation of public trust, by means of *adequate education, service and further research work.*

The educational phase must be divided into two definite plans; namely, better training

in medical schools, by encouraging the students to become more interested in psychiatry, adequate training of younger members of the hospital staff, and the second plan should be based on the general education of the public, by introduction of the subject of mental hygiene in the curriculum of public schools and colleges.

Adequate psychiatric service has not been available to *the mass of our population.* It is very common not to find a psychiatrist within a radius of over one hundred miles. Most of the psychiatrists are located in large cities and in mental hospitals.

Psychiatric service rendered by hospitals and clinics has never been on the same basis as the services of other branches of medicine in general hospitals. Complete reorganization of hospital service should be recognized as being necessary. A uniform requisite for admission should be considered as vital. Outside of a few, the majority of cases should be considered on a voluntary admission basis. Through education such a procedure will become the rule rather than the exception.

State hospitals for mentally ill should be so well planned that the public will accept them on the same basis as general hospitals.

A true medical and psychiatric service can be rendered to the patients of our hospitals through competent personnel which cannot be obtained in any state without consideration of salaries and wages of such a personnel.

Related to the matter of research is the whole system and practice of clinical records. Much valuable material that goes into case records is merely filed away and never used for research purposes. The system and practice of clinical case records should be reviewed, and the system should be set up with an eye to the research value of these records.

Every member of the staff of each hospital should be encouraged to devote a certain number of hours per week to research.

DELAWARE STATE HOSPITAL

Delaware State Hospital was established fifty-six years ago, with a population of 119

patients, with an objective to safeguard the society and create a decent existence for the unfortunates committed to the hospital.

Today the Delaware State Hospital has a population of about 1250 patients in the hospital and 400 on parole under its supervision.

The objectives of the Hospital are as follows:

The safety of the community.

Adequate care and treatment of acutely and subacutely mentally and nervously ill.

Proper and humane care of chronically ill.

Observation clinic for maladjusted and early stages of mental and nervous illnesses.

Mental Hygiene clinic for diagnostic, therapeutic and preventive purposes (for adults as well as children, including public schools and juvenile courts).

The examination of cases for the State and City Courts, penal institutions, industrial schools, the Delaware Colony for Feeble-minded and other state, county and city institutions.

The examination of problem cases referred by physicians, by the state, county and city Social agencies, as well as private agencies.

Training resident internes in psychiatry and neurology.

Training young women for the nursing profession in the training school of the hospital.

Training senior student nurses of all general hospitals in the state of Delaware, in the art of psychiatric nursing, for a period of three months for each group, (about 40 students in each group).

General education of the public, thru lectures, meetings and conferences.

Hospital and ambulatory treatment of veterans in need of such service.

The sterilization of mentally unfit, who are at large.

The hospital is approved by the American College of Surgeons, American Medical Association, American Hospital Association, and is affiliated with the Delaware Hospital, Wilmington General Hospital, Memorial Hospital, St. Francis Hospital, all of Wilmington, Easton Emergency at Easton, Md.; Beebe Hospital at Lewes, and Milford Memorial Hospital at Milford.

The hospital is under the control of the

State Board of Trustees, consisting of nine members, three from each County; four of the nine members are physicians.

At no time during the past fifty-six years have politics played any role in the administration of the affairs of the hospital.

Since December 7th, 1941, the hospital has adhered to the principle that every department of the state government must contribute directly or indirectly to winning the war, by giving priority to activities, which will best promote war work, by postponing non-essential operations and by taking every step to conserve manpower and materials.

The motto of the hospital is to utilize the latest scientific methods in the treatment of mentally and nervously ill patients, in an attempt to cure the highest percentage possible, thus rehabilitating them and creating an asset to the community.

The existing housing conditions of the hospital have seriously handicapped the proper care and treatment of those who have been entrusted to the Delaware State Hospital for the past ten years.

MENTAL HYGIENE SERVICES IN THE WAR NURSERY SCHOOLS

CATHERINE T. GIBLETTE,*

Farnhurst, Del.

Peter stood defiantly in the war nursery school group. His eyes snapped and he stamped his foot as he exclaimed, "I won't!" He picked up the blocks near him and threw them without regard for the safety of his playmates. He grabbed a chair and threw it into the circle of children from which he was being led—or pulled—to a corner of isolation with his teacher. Peter's only code was to fight for his rights. The nursery school teacher knew that his behavior pointed to fighting in his home. She recognized also that Peter was a leader. In his few days of attendance the children were following his suggestions—"When he is good, they are all good. When he is disturbed, they are all disturbed." The supervisor recognized the need for psychiatric service for the boy and his family and referred the problem to the Mental Hygiene Clinic. Peter was an animated little man during his clinic visit.

* Psychiatric Social Worker, Delaware State Hospital.

His black eyes sparkled as he investigated his new environment. The psychologist found him original and cooperative. He occasionally reflected his home training in his test responses, during the examination. For instance in the problem of opposites—to the item—Father is a man, mother is a——, Peter answered, "A battleaxe." Likewise when the social worker was in the home, the child contributed to the history. His mother commented, "I am Polish, and his father is an Italian." A grown cousin added, "I am Russian." At this point Peter exclaimed, "And I am a rat!" The psychiatrist found the boy normal and responsive, and stated, "He has excellent potentialities for training and education. His present behavior difficulties are obviously the result of inadequate home-training. With careful and patient handling he should respond well to nursery school training." Suggestion was made that the mother come to the clinic for occasional interviews.

The nursery school teachers and the clinic worked together. Several weeks of improved behavior followed each clinic contact, and finally Peter was reported to be adjusting well in the first grade. On the boy's last visit to the clinic his mother, who had accompanied him, told the psychiatrist that she thought the improvement in her own adjustment was reflected in that of the boy.

Peter is only one of the nursery school children with problems. William is over-shy and uses infantile speech (baby talk). He is afraid of the children and clings to his teacher. Ruth has violent temper outbursts and "screams for fifteen solid minutes" after she is led from the group. Then she returns smiling as if nothing had happened. Her older sister, who also is the nursery school, has been taught by her parents to rush solicitously to the child when she hears the screams. Mary and Freddie are brother and sister. Mary is unable to share her brother with the children. She is angered at any attention shown him. At lunch she sits with her arm around his neck. During the rest period, when each child sleeps on a separate little cot in a large room, Mary sobs and finally cries herself to sleep after begging to be allowed to lie by her brother. The boy,

in turn, never smiles while his sister is unhappy. Bobby comes from a home where the father is alcoholic. The child is tense from living amidst friction and quarreling. He knows the additional insecurity of his father's having gone overseas. He so longs for affection, that he throws his arms around strangers who visit the school. Joan also comes from a home where the family situation is tense and unhappy. She is hyperactive, destructive and completely undisciplined.

The war nursery schools have brought these children of working mothers into a situation where assistance is available for handling beginning maladjustments. Many of the nursery school children are normal well-behaved youngsters whose manner soon is emulated by those who have been less fortunate in their babyhood home training. Without the opportunity of the nursery school, the home situation which creates or intensifies a predisposition to emotional instability—continues endlessly and the child's undesirable adjustment becomes more deep-seated.

The war nursery schools of Wilmington, Delaware, are a part of the nation's huge industrial program of winning the war. (1) Baruch says, "The existence of the child care centers has helped to maintain a mighty labor force of fifty-four million people including more than eighteen million women workers—without this labor force we would not have been able to prosecute the war effectively and to equip our fighting men." Figures show as high as 64 per cent of mothers among these women. During the working hours of the mothers the war nursery schools are substituting for the homes. Some families bring the children so early in the morning that breakfast is part of their program, and several babies are put to bed to complete their night's sleep. All the children return to their home in the evening. The war nursery schools are not the residential nurseries that have been established in the war stricken countries where evacuation was necessary. The American children have not been exposed to the tragic bombings and terrifying killings in their presence. They have not experienced the emotional trauma of the children of England which are well described in (2) Infants

Without Families. The American children in the war nursery school are from average working homes of men and women with average educational background. Pre-school service by expert teachers and counsellors for years has been available to well-to-do families. It is the war situation that has extended to the working people greater privileges of assistance in child care.

The war nursery school has demonstrated its contribution to the physical, mental and emotional development of the child. It is hoped that the (3) Lanham Act which has made the services to children possible, and the agencies through which the Act functions—that is, the Community Service for Federal Public Housing and the Boards of Education—not only continue but extend the powers to make the public nursery schools an integral part of the school system.

- (1) Baruch, Dorothy W.; When the Need for War-Time Services for Children is Past—What of the Future; Jr. of Cons. Psych. 1945, Vol. IX, No. 1, Jan.-Feb.: 45-57.
- (2) Freud, Anna, and Burlingham, Dorothy T.: Infants Without Families; International University Press, New York, N. Y.
- (3) Public Law 158, Seventy-Eighth Congress.

M. A. Tarumianz, M. D., addressed the Seventh Councilor District (composed of five County Societies) of the Medical Society of the State of Pennsylvania in Williamsport, Pa., on Friday, May 11th, 1945.

Dr. Tarumianz's subject in the morning session was "Psychiatry in the Post War Era."

In the afternoon session his subject was "Mental Hygiene and the Community."

Extracts May Give Protection Against The Rash of Poison Ivy

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tion' are so large that rashes and gastrointestinal symptoms have occurred in almost all experimental subjects. These reactions are said to be negligible when the same amount of extract is administered in smaller doses over a period of seven or eight months. So far, none of these potent extracts for oral therapy (treatment by mouth) have been marketed or submitted to the Council for con-

sideration. There is no satisfactory evidence that the skin tests or resistance against ivy on rigorous exposure has ever been modified except by the aforementioned procedure, a procedure which its instigators imply is possibly unsafe except under experienced supervision and probably not worth while because the resistance seems but temporary. . . ."

Dr. Stevens explains that since there is no controlled statistical evidence that the daily ingestion will give protection, the method of choice for "immunization" against ivy appears to be by inoculation with repeated doses of extract begun well before the season and increased in strength at frequent intervals within the tolerance of the patient. There is clinical evidence supported by statistics that intramuscular (into a muscle) inoculations have conferred resistance on susceptible persons. The series of doses used for "immunization" however should be controlled by the doctor according to the tolerance of the patient and therefore prepared so that he may have enough latitude to meet the varied requirements of the individual patient.

In closing, he says, "The treatment of the acute rash with ivy extracts should be discouraged, because many patients are made worse and there is no satisfactory evidence that any are helped."

VITAMINS AND SODA

The general impression that all vitamins are rapidly destroyed by soda or by basic solutions is far from correct, it is advised in the April issue of *Hygeia*, *The Health Magazine*. In answer to a query *Hygeia* says:

"True some of the vitamins, such as vitamin C, thiamine and riboflavin, are more easily destroyed in basic solutions than in acid or neutral solutions, but even here destruction depends on time and other stimulating factors. Some vitamins, such as biotin and folic acid, are more stable in basic solutions than in acid solutions. Nicotinic acid, for example, is more soluble in the presence of soda than in pure water solutions."

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